



HOOSIER HEALTHWISE ENROLLMENT CHECKLIST

Participant's Name _____ Date of Birth _____

- Completed COMBINED ENROLLMENT FORM (Part I & II)
- Completed Hoosier Healthwise Supplemental forms (as appropriate)
 - Application for Hoosier Healthwise for Children and Pregnant Women Supplement
- Signed RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAL ASSISTANCE PROGRAM consent form. (Two signatures from the parent and one signature from the interviewer are required.)
- Income verification (one month's income verification must be enclosed...if the previous 3 months income varies, please provide verification for those months' income as well).
- Supporting medical documentation verifying pregnancy to include number of fetuses, if applicable.
- Selection of a primary care physician has been made through the Benefit Advocate.
Name of physician _____
(If selection of a primary care physician has not been made, one must be selected within 10 days of submission of the enrollment packet.)

Person taking enrollment application:

Name: _____

Telephone #: _____ Fax #: _____

Application Date: _____ Date mailed/delivered: _____

Completed enrollment packet must be received at the local Office of Family and Children in the county in which the child resides within 35 days of the application date. (Please see the First Steps/Hoosier Healthwise contact list for specific names and addresses.)

If applying for **MEDICAID FOR THE DISABLED (M.A.D.)**

In addition to the requirements above,
Please include the following:

- Memo to the OFC staff to review the file for M.A.D.
- Signed RECIPROCAL MEDICAL RELEASE for any medical providers from which information may need to be sought.
- Signed PHYSICIAN'S HEALTH SUMMARY to include information on the diagnosis, medical condition and any medications taken.
- Supporting medical information that may be helpful in determining the child's medical needs.